COMMUNITY TRANSITIONS MANUAL

FOR SUPPORT COORDINATORS

AND

COMMUNITY LIVING COORDINATORS

DEVELOPMENTAL DISABILITIES
Missouri Department of Mental Health
DIVISION OF DEVELOPMENTAL DISABILITIES

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TRANSITIONS FOR INDIVIDUALS ALREADY RESIDING IN THE COMMUNITY

TRANSITIONS FOR INDIVIDUALS LIVING IN THEIR NATURAL HOME

1. Anytime an individual is moving within or out of their current region, the Support Coordinator (SC) will discuss with the individual or guardian the choice to transfer or discharge from services.

2. If the legally responsible person chooses to continue with services for the individual, the sending Support Coordinator Supervisor (SCS) will e-mail the following staff about the upcoming move:

    - Receiving SCS;
    - Transfer contact designees at the sending/receiving Regional Offices; and
    - Transfer contact designees at the receiving TCM entities.

    An electronic copy of the Individual Support Plan (ISP) and demographic page will be attached to the e-mail.

3. The receiving Regional Office (RO) transfer contact designee will inform the responsible RO staff person so a second Episode of Care can be opened, providing both parties the ability to bill and have access to CIMOR during the time of transfer.

4. If the individual receives funded services which need to continue in the new location, the sending SC and/or SCS will work directly with the receiving SC at the TCM agency or RO to ensure services are set up in advance of the move. An amendment or updated ISP will be completed prior to the individual's move.

5. The sending SC will submit the amendment for authorization of services to the sending Utilization Review Committee (URC). The sending SC will share the approved budget with the receiving SC at the TCM agency and receiving RO.

6. Complex individual service needs shall require a transition meeting to ensure all necessary supports and services are in place. The need for a transition meeting will be determined by the sending and receiving TCM agencies prior to the move.

7. Once services are coordinated and authorized, the transfer may occur. It is the responsibility of the sending SC to provide an up-to-date ISP or amendment to the receiving SC upon transfer.

TRANSITIONS FOR INDIVIDUALS RECEIVING PAID SERVICES IN DD RESIDENTIAL SETTINGS

Choosing a Provider

1. The sending SC shall ensure that the referral for any individual seeking a different residential setting shall be entered into the Consumer Referral Database. The sending SC shall electronically send the Consumer Referral Profile and referral documents including the ISP, Consumer Referral Profile, and other relevant documents to the sending Community Living Coordinator (CLC) who will place the documents in the Consumer Referral Database.

2. The CLC shall check all individuals seeking a residential setting to determine if they are on a sex offender registry.

    - For any adult - the CLC will check the online Missouri Highway Patrol Sex Offender Registry to determine if the individual is a registered offender.
    - For any juvenile (under the age of 18) - the CLC will check both the online Missouri Highway Patrol Sex Offender Registry and the Juvenile Sex Offender Registry via letter to the Juvenile Office in the individual's current county of residence.

    The CLC will document, on the Consumer Referral Profile Form, that a check of the sex offender registry(ies) has been completed. Notification procedures outlined in the Forensic Notification Process (page 28) will apply to all individuals found to be on a sex offender registry.

3. SCs will encourage individuals and families to review profiles of potential support providers available on the Department of Mental Health (DMH) website at http://dmh.mo.gov/dd/.

4. The sending SC shall use the Housemate Compatibility Tool (Appendix A) to assist the team in considering individual preferences in the selection of a home. The tool shall be added to the referral information in the Consumer Referral Database when completed.

Planning the Transition

1. Once a provider is identified, the sending SC shall notify the following individuals by e-mail:

    - Sending and receiving CLC;
    - Receiving SCS;
    - Transfer contact designees at the sending/receiving ROs; and
    - Transfer contact designees at the receiving TCM entities.

    The SC shall attach an electronic copy of the ISP and demographic page to the e-mail.

2. The receiving CLC will notify their RO nurse of the move.

3. The sending SC and CLC will arrange and co-facilitate a transition meeting far enough in advance of the move to ensure a smooth transition. Participants in the transition meeting will include all staff necessary to provide input to the ISP. The sending and receiving RO nurses should be members of the team when appropriate. If behavioral risk is anticipated or a Behavior Support Plan (BSP) is in place, the CLC from the sending RO will contact the Area Behavior Analyst, if available. If an Area Behavior Analyst is not available, the CLC will make a referral to the Behavior Resource Team at the receiving RO.

4. The sending SC will document the plan for the move in an ISP amendment. The ISP amendment shall include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports.

5. The sending SC will arrange for the individual to visit the new support location and support persons. If visiting the new home is not in the best interest of the individual, staff may introduce the individual to the new setting through pictures, videos, or other methods.

6. The SC shall utilize the Checklist for Community Living Moves (Appendix B) as a planning tool throughout the transition process.

7. The receiving transfer contact designee will inform the responsible RO staff person to open a second Episode of Care.

8. The sending and receiving CLCs will identify the main contacts to assist the SC with questions regarding services and resources available in the area where the individual is moving.

9. The sending SC will have the individual or guardian sign all necessary documents (i.e. Provider Choice of Support Coordination and Services).

10. The sending RO's URC remains responsible for approving plans and budgets for the individual. The sending SC will share the proposed budget with the receiving RO's transfer contact designee. The receiving RO is responsible to provide assistance to the staff from the sending RO (including SC's, UR, Business Office, and Administration) as needed to ensure the accuracy of the information contained within the plan and budget.

11. If the individual has had a significant change in health or is moving from their natural home, the sending SC will complete a Health Inventory prior to the individual moving (Division Directive 3.090 Health Identification - Planning System Process).

12. In the event the individual is moving to a new provider directly from a hospital, the sending SC will ensure the receiving provider is prepared to support the individual's medical needs by:

    - Contacting the hospital as soon as possible after admission to request participation in discharge planning; and
    - Ensuring the receiving provider has been provided all written medication orders as well as training and instruction regarding care procedures, techniques, use and monitoring of equipment, and other elements of care.

    The sending SC will ensure that the sending and receiving RO nurses are involved in the planning process to assist the team for coordinating needed medical follow-up.

Post-Move Follow-up

1. After the move, the sending TCM agency and RO will maintain responsibility for the individual and support coordination will be co-facilitated with the sending SC as the lead. The sending SC is responsible for completing support monitoring. However, in an instance where the travel distance is significant, it may be necessary to have support monitoring completed by the receiving SC. Every attempt will be made to accommodate a reasonable request for assistance with support monitoring due to distance. The sending and receiving support coordination agencies will come to an agreement on what is a reasonable distance and will decide who will provide support monitoring during the first 30 days.

2. For the first 30 days after the move, the following will occur:

    - The receiving provider will bill the sending RO for approved services until the effective date of transfer; and
    - Event Report Forms will be sent by the provider to the receiving RO and SC where they will be entered into CIMOR. The receiving RO will send a copy of the Event Report Form (the Event Report Form shall be marked **COPY**) to the sending SC (Division Directive 4.070 Event Report Processing and 9CSR 10-5.206).

3. A post-move review meeting or call will be held within the first 15 to 30 days after the move. The post-move review meeting/call will be jointly facilitated by the sending SC and CLC to include, but not limited to, the receiving SC, receiving CLC, and provider. Outcomes and action steps may need to be developed at this meeting. If so, the sending SC will document those in a plan amendment.

4. During the post-move review meeting, the transfer date will be determined. The transfer will be completed within 30 days of the move.

5. The sending SCS or TCM transfer contact will electronically forward a completed Transfer Form (Appendix C) to the appropriate receiving TCM transfer contact and RO transfer contact designees. The sending SCS or TCM transfer contact will verify that all items on the file audit checklist are contained in the file.

6. After review of the Transfer Form, the receiving transfer contact designees or receiving TCM transfer contact will respond within three business days of receipt via e-mail. The effective date of transfer, along with an address to mail records, will be included in the response to the sending TCM transfer contact and transfer contact designees. The Episode of Care will end for the sending RO one day prior to the date of transfer.

ADMINISTRATIVE FILE TRANSFER PROCESS

All files from the sending RO and sending TCM entity, including current and historical (electronic or hard copy), shall be sent to the receiving TCM entity within five business days of the effective transfer date. If the sending RO has a manila file with information listed below, it shall be sent directly to the receiving RO. If the receiving RO does not receive a manila file, the TCM agency shall forward the following list of original documents to the RO:

1. All legal documents including Guardianship letters, Conservatorship letters, court orders and other custody documents, marriage certificates, birth certificates, etc.; and
2. All admission documents including eligibility determination and admissions information, assessments and reports used to determine eligibility, application information, client rights receipt, client choice documents, diagnosis sheet, and supporting documentation.

Any paper records being forwarded need to be hand-delivered or mailed by USPS certified with return receipt. Please refer to Division Directive 1.060 for storage, retention, and destruction information on records.

FREQUENTLY ASKED QUESTIONS REGARDING TRANSITIONS

1. **What process should be followed if an individual needs an emergency residential living situation?**

   The sending SC will ensure that basic health and safety information will be sent to the provider before the individual moves. In the event that a move occurs without the prior planning described in the guidelines, the sending CLC and SC will ensure that a transition meeting is arranged as soon as possible, but no later than two weeks following the placement. The sending RO and TCM provider will maintain responsibility for the individual until a transition meeting can be held.

2. **Who maintains responsibility when an individual is residing in respite in another region?**

   When an individual is residing in another region in a respite situation, the current TCM provider and RO will maintain responsibility for all services including TCM, service authorizations, incident reporting, etc. If a decision is made for the individual to permanently reside in the new region, the transfer procedures will then be in effect.

3. **How are transitions involving Children's Division handled?**

   Transitions involving children in the custody of the Children's Division will follow the procedures outlined in the transition manual to ensure that communication necessary for planning occurs and all necessary supports and services for the health and safety of the child are in place. Providers accepting children through child-specific contracts are responsible to inform their SC and RO of the placement before it occurs. This allows the teams for other individuals in the home an opportunity to consider roommate compatibility and adjust the budgets as needed.

   The RO or TCM provider serving the location of the Children's Division placement will be asked to provide TCM service coordination while the child is living in Children's Division placement. If a child is placed in a very short-term placement (e.g. 30 to 60 days) with intention of returning to his/her home area, the sending and receiving ROs will determine, on a case by case basis, if a transfer will be completed or if the sending RO will maintain responsibility.

4. **What if an individual's eligibility is questioned by the receiving TCM provider during the transfer process?**

   If an individual who has been determined eligible for DD services transfers and eligibility is questioned by the receiving RO or TCM provider, the transfer will be accepted and a review of eligibility will be completed by the receiving RO Intake Team with formal documentation of the review completed. If the review does not confirm that the individual is eligible for services, then the receiving RO will begin the formal redetermination process.

5. **What if an individual moves during the intake process?**

   In the event an individual moves prior to being determined eligible during the intake process, the sending RO will complete the intake and transfer the individual to the receiving RO and TCM provider without an ISP being completed. The receiving TCM entity will complete the initial ISP as with all new intakes.

6. **Who should be involved if an individual who receives self-directed supports moves from one area to another?**

   If the individual who is moving receives self-directed supports, the sending and receiving Self-Directed Supports Coordinator (SDSC) must maintain communication and follow up closely during the transition process to ensure a smooth transition. The SC will inform the current SDSC of the individual's plan to move. The sending and receiving SDSC's will collaborate to ensure timesheets and billing are in place and the services are authorized to begin in the new location on the correct date. The sending SDSC and receiving SDSC will coordinate who will notify the Fiscal Management Service (FMS) regarding change of address and other needed information. The receiving SDSC will notify FMS of the updated SC and SCS and is responsible for ensuring that FMS receives all updated and current information. The receiving SDSC will work closely with the accounting office to ensure that the authorization is transferred.

7. **How are transitions handled for an individual who is participating in the Partnership for Hope waiver?**

   If the individual utilizes Partnership for Hope (PfH) services and transfers to a county that also participates in PfH, the services should continue and will be funded through DMH until the end of the fiscal year. At the end of the fiscal year, PfH services will be reauthorized with the match being split by DMH and the receiving county.

   If the individual utilizes PfH services and they transfer to a county that does not participate in PfH, services will need to be terminated. Before the transfer occurs, the sending SC will inform the individual/guardian of why the PfH services are being terminated and assist with coordinating services through natural resources. There is no appeal process regarding this termination.

8. Does funding from an SB 40 Board transfer with the individual?

If the individual is utilizing funds from an SB 40 other than PfH, the sending SC will inform the individual/guardian that these funds will not transfer. The sending SC will seek and advocate for services to meet the needs that have been covered by funds that will not transfer.

9. What should accompany an individual to a new residential living situation?

At a minimum, the following must be provided to the receiving provider no later than the day of the move:

- Current ISP, including any addendums and budget authorizations;
- BSP;
- Current physician's orders;
- A minimum of a seven day supply of current medications;
- Current physical, vision, and dental exams;
- Current specialized medical information;
- Information regarding diet and allergies;
- Medicaid, Medicare, and Social Security cards;
- Current immunization record;
- Adaptive equipment;
- Clothing;
- Personal care items;
- Personal property inventory;
- Documentation of guardianship and payee; and
- Funding authorization.

Personal spending money which has been assigned to the individual will move with the individual. Personal spending money still in the provider's account will be returned to the RO, or as otherwise directed by the RO.

10. Do both sending and receiving ROs need to sign the budget?

No. The sending RO signs the approved budget and shares with the receiving RO.

11. Should a transfer occur if a child who lives with his family attends a residential school in another region? (Such as Missouri School for the Blind, Missouri School for the Deaf, etc.)

No. The child's residence has not changed; therefore a transfer would not occur.

FORMS

Housemate Compatibility Tool (Brief Version)

Checklist for Community Living Moves
(revised version posted for comment)

Transfer Form

Consumer Referral Profile

Optional Housemate Survey Tool (Detailed Version)

Optional Risk Screening Guide

TRANSFER CONTACT INFORMATION

Support Coordination Transfer Contacts Brochure

TRANSITIONS FROM HABILITATION CENTERS

HABILITATION CENTER TRANSITION PROCESS

Choosing a Provider

At least quarterly, the team for an individual residing in a state-operated program will review and assess supports that would be necessary for that individual to live in a less restrictive setting. If the team identifies that an individual could live successfully in the community, or the individual, guardian or other person close to the individual advocates for transition to the community, then process for transition from a Habilitation Center will begin. To read more about this process, refer to Division Directive 4.170.

Transitions from Habilitation Centers are facilitated by a Transition Coordinator. The Transition Coordinator and/or the Habilitation Center Social Service Worker (or designee) will contact the individual/guardian. They will discuss community placement options that will be available to the individual in the community including:

- Group homes;
- ISL;
- Shared living options;
- Host family arrangements;
- Self-Directed supports;
- Work options; and
- Necessary medical and behavioral supports.

The Transition Coordinator and Habilitation Center Social Service Worker (or designee) will assist the individual/guardian in identifying a preference for location and discussing any questions they have. This discussion shall include a description of the transition process regarding visits, team meetings, and post-move reviews.

In addition to all other transition practices outlined in this document, if the individual/guardian decides to pursue the option of self-directed supports:

- The SDSC at the RO covering the area where the individual will live shall be a member of the individual's interdisciplinary team.
- The SDSC and receiving SC will assist the individual/guardian in the process to enroll in the Self-Directed Supports service system.
- Transition planning will focus on:
    - Hiring an agency-based Support Broker, if needed;
    - Determining how staff shall be hired and trained;
    - Determining roles and expectations of staff;
    - Locating housing, if needed;

- Referrals to community medical supports;
- Referrals to support agencies; and
- Determining emergency procedures.

If the individual/guardian decides to pursue community transition to a residential provider, the Habilitation Center Social Service Worker (or designee) shall send the following information to the CLC at the RO most closely associated with the Habilitation Center. The CLC shall attach the following information to the referral in the database for viewing by prospective providers:

- Current ISP and any addendums;
- Consumer Profile;
- BSP, if applicable;
- Most current Nursing Review;
- Housemate Compatibility Survey; and
- Other information the team deem necessary for a provider to determine if they could support the individual, if applicable.

The CLC shall inform the Transition Coordinator of all providers who express interest in supporting the individual. The Transition Coordinator and/or Habilitation Center Social Service Worker (or designee) shall contact each provider to explore the supports the agency can provide.

The Transition Coordinator and the Habilitation Center Social Service Worker (or designee) shall contact the individual/guardian to provide information regarding the providers that have responded, including the providers' contact information. The Transition Coordinator will encourage individuals and families to review profiles of potential support providers available on the DMH website at http://dmh.mo.gov/dd/consfam/. The Transition Coordinator shall facilitate contact between the individual/guardian and the provider if it is in accordance with the individual/guardian's wishes. The Transition Coordinator shall inform the guardian that they may invite family members, friends, or other advocates of their choosing to be a part of the transition process.

If the person has required behavioral supports in the form of strategies included in the ISP or BSP, psychotropic medications, or any crisis management techniques were utilized in the past year, the Habilitation Center Behavior Support Professional will ensure there is a current functional assessment for the behaviors and the strategies or BSP is current and effective. Data for at least the past year will be summarized in graphic format, including any significant environmental events that may affect the behavior, medications, and changes in medications. The BSP, functional assessment, and data will be included in the information provided to chosen providers. If behavioral risk is anticipated or a BSP was necessary at the Habilitation Center, the Transition Coordinator or the CLC from the sending RO will contact the Area Behavior Analyst,

if available. If an Area Behavior Analyst is not available, the Transition Coordinator or CLC will make a referral to the Behavior Resource Team at the receiving RO.

Ongoing person-centered career planning is expected to be addressed in the ISP for all individuals. DMH Employment First Specialists may be contacted to provide technical assistance. Tools outlined in the ISP Guide should be utilized to assist in supporting the individual with exploring their employment support needs and career pathways.

Upon individual/guardian approval, visits are set up for the guardian, individual, Transition Coordinator, Habilitation Center Social Service Worker, and anyone who the guardian or individual invites to visit the potential homes. The Transition Coordinator or CLC from the sending RO shall notify the CLC of the receiving RO that the visits are occurring.

The individual/guardian shall then make a decision as to which provider they want to support the individual in the community. If the individual/guardian does not choose any of the providers, then additional providers are sought through the Referral Database and the process of exploring potential providers continues until the individual/guardian selects a provider. The team may consider expanding the counties of preference in the Referral Database to ensure more responses.

Planning the Transition

Once an agency has been chosen by the individual/guardian, the Transition Coordinator shall notify the receiving RO CLC that the individual will be transitioning to an agency in the receiving RO's area. The Transition Coordinator shall notify the receiving TCM entity and the provider of the transition. Careful consideration must be given by the team to make sure the individual is compatible with potential housemates. The Housemate Compatibility Tool (Appendix F) may be used in considering the compatibility of potential housemates. New ISLs will be inspected by the receiving SC utilizing the ISL Environmental Site Review Form.

The Transition Coordinator shall schedule the initial transition meeting. The individual's interdisciplinary team should include:

- The guardian and any other family member, friend, or advocate who the guardian or individual invites to attend;
- The individual;
- Provider agency staff (DDP, lead staff at the home, agency RN);
- Receiving RO staff, as necessary (CLC, SC, RN, and Behavior Resource Team Member);
- Habilitation Center staff (physician, RN, LPN, Social Service Worker or designee, Unit Manager, Program Supervisor, Habilitation Specialist, Recreation staff, Dietary staff, Psychologist/Behavior Support Professional, direct support staff);

- Transition Coordinator;
- Receiving SC from SB 40 Board/TCM entity, if applicable;
- SDSC from receiving RO, if the individual/guardian has chosen self-directed supports;
- Behavior Resource Team staff from the receiving RO, if behavioral risk is anticipated; and
- Any additional persons essential to the planning process.

The Transition Coordinator facilitates the transition meeting during which detailed discussion is held regarding the supports that must be in place for the individual to be successful in the community. The Initial Transition Meeting Discussion Document (Appendix A) guides the team in the transition planning process. The team shall also ensure that risk mitigation planning is part of the transition process, using the Risk Screening Guide (Appendix B) or a similar risk assessment tool.

During the initial transition meeting, the team shall schedule visits for the direct support staff from the provider agency to shadow the individual at the Habilitation Center during various times throughout the day and overnight, if needed. The team will determine particular times that are most important for staff to observe based on the individual's support needs. Behavior support professionals at the Habilitation Center will provide competency-based training in the individual's behavioral support strategies to support staff at the community provider agency.

The team shall also schedule visits, including overnight visits, for the individual and staff from the Habilitation Center to spend time in the new residence with the receiving provider staff. The purpose of the visits is for staff to offer suggestions and identify support needs for the individual in the new environment. Extent and nature of the visits should be individualized, with the goal of helping the individual to feel as comfortable as possible in his or her new residence before the move. If visiting the new home is not in the best interest of the individual, staff may introduce the individual to the new setting through pictures, videos, or other methods.

The Transition Coordinator shall ensure that the proposed provider has a copy of the ISP prior to an overnight visit. The Habilitation Center Social Service Worker (or designee) shall provide the provider with the Transition Visit Profile (Appendix C) which contains information regarding specific risk factors for the individual and emergency contact information. Staff at the Habilitation Center shall help prepare the individual for his/her experience in the new environment. The Behavior Resource Team will be involved in the planning for transition, visits to the new home, and ongoing support and consultation when the individual moves from the Habilitation Center. The Behavior Resource Team should assist in the evaluation of the needs in the new home environment to ensure successful supports and the best quality of life.

The Habilitation Center Behavior Support Professional will review the behavioral support strategies with the provider and the Behavior Resource Team. The Habilitation Center Behavior

Support Professional will make any adjustments necessary to the strategies based on information from the team and new provider.

During the initial transition meeting, the Transition Coordinator will schedule and facilitate additional and/or final transition meetings to discuss any issues that arise during the visits and also to finalize the Transition Plan. The number of transition meetings that are held will depend on the needs of the individual and whether any obstacles are encountered in setting up the supports in the community.

The Transition Coordinator shall develop the Transition Plan from review of the ISP, the individual's Placement Plan, and the team discussion at the transition meetings. The Transition Plan must identify all supports, services, accommodations, equipment, furnishings, etc. needed for the individual to be successful in the community and shall be developed in accordance with the Division of Developmental Disabilities ISP Guide as well as Division Directive 4.060 Individual Support Plan and Level of Care.

At the final transition meeting, the team confirms that all supports needed by the individual, including employment referrals, doctor's appointments, adaptive equipment needs, etc., are in place. The team will set a tentative move date with moving procedures as outlined in the Initial Transition Meeting Discussion Document (Appendix A). Post-move review dates will be set up for 30, 60, and 90 days following the move.

The Transition Coordinator shall determine whether the individual qualifies for the Money Follows the Person (MFP) Grant and if so, submit MFP documents to the CLC.

The Transition Coordinator shall submit the Transition Plan, budget information, and all necessary waiver paperwork including the ICF-DD Level of Care Statement, service authorization documentation, the Medicaid Waiver, Provider, and Services Choice Statements to the sending RO's URC for approval. The sending RO shall request a waiver slot for the individual. Once the URC and Regional Director have approved the Transition Plan and budget, the team will confirm the final move date. The Transition Coordinator shall complete the Health Inventory. The sending RO will transfer the individual to the receiving RO effective the date of the move. The receiving RO/TCM entity is responsible for support coordination the day the individual moves.

On the day of the move, the staff from the Habilitation Center and, when possible, the Transition Coordinator, shall accompany the individual to the new home. The current Medication Administration Record, current medications and/or medication orders to provide at least a 15 day supply of medication, current physician's orders, current lab results, current annual physicals, current ISP, current BSP, and information regarding upcoming doctors' appointments will go with the individual to the home. The Transition Coordinator will provide copies of the documents to the new provider if the documents have not already been provided. The Inventory

Checklist (Appendix D) is completed by staff at the Habilitation Center and also will accompany the individual to the new home.

The individual's record will be transferred from the sending Habilitation Center to the receiving RO. If the individual will receive support coordination from a TCM entity other than the RO, the receiving RO will transfer the record to the TCM entity.

Post Move Follow-up

The receiving SC will make weekly visits to the individual for the first 30 days. The transition team will hold the 30, 60, and 90 day post-move reviews on the prescheduled dates at a location chosen by the individual/guardian. Any additional support needs and adjustment concerns will be discussed and the frequency of future home visits will be determined. Also, the receiving SC will monitor purchases made for the individual through the Community Transition service and discuss any additional items or changes in items needed with the transition team. The Transition Coordinator will facilitate this meeting, complete the Post-Habilitation Center Transition Review Form (Appendix E), and send it to all team members. The receiving SC will review and approve by signing the form or documenting approval via email to the Transition Coordinator. The receiving SC will complete an addendum to the ISP which includes objectives for implementation in the community. The date of the annual ISP does not change. If there are concerns at the 90 day post-move review, additional monthly review meetings may be scheduled by the team.

The Behavior Resource Team will assist the SC and support provider to utilize positive, proactive, and preventative strategies that have the best chances of supporting the individual with a good quality of life. The Behavior Resource Team will provide at least weekly onsite visits and consultation for the first month and at least bi-weekly onsite visits and consultation for the next 60 days to assist with consistent utilization and adjustment of strategies of support recommended by the Transition Team. If the individual has a behavioral support plan, the individual will have behavioral services ongoing in the community and will be referred to the Regional Behavior Support Review Committee.

TRANSITION RATE AND PROVIDER REIMBURSEMENT

The daily rate shall be determined utilizing the individuals current Rate Allocation Score and the associated rate determined during the fiscal year of transition. If a current Rate Allocation Score is not available, the rate shall be determined as outlined in Provider Bulletin 01 http://dmh.mo.gov/dd/docs/providerbulletinassessmentprocess.pdf. The current rates associated with the Rate Allocation Score can be obtained from the Transition Coordinator.

If a person's daily rate for all services combined is lower than the minimum identified transition rate* set by the Division of Developmental Disabilities, the minimum transition rate will be the rate used. The current transition rate can be obtained from the Transition Coordinator.

*The transition rate is a combined daily rate which includes residential and all other habilitation support services. The rate shall be used to purchase all necessary community services determined by the ISP (i.e. this is an all-inclusive rate). If the transition is used, it shall be in effect for 18 months after services begin. No later than 18 months following transition, the Provider Relations team member assigned to the provider will review the budget with the provider. If the individual continues to require services at the transition rate, the rate will continue. If the individual does not require the level of services covered by the transition rate, the Provider Relations team member will work with the provider to determine where the additional funds can be reallocated within the provider agency.

Flexibility to use the approved transition reimbursement rate will be offered to community providers to help providers expand capacity to serve additional individuals. For example, a provider may use some of the funds to move an individual living in a group home into another living arrangement more suitable to meet their needs and use the empty bed to meet the needs of an individual residing in a Habilitation Center requesting group home services. The process must not exceed the approved transition reimbursement rate per day in total.

Individuals moving into existing residential settings that have an established rate will be invoiced to the department at the current residential daily rate plus an additional amount authorized as intensive residential habilitation to produce the established transition reimbursement rate per day.

The provider chosen to work with the individual may be reimbursed for administrative costs necessary to the transition process including, but not limited to:

- Staff training;
- Staff shadowing individuals at the Habilitation Center to get to know them and be coached on their support needs by Habilitation Center staff. Staff costs associated with housemates becoming acquainted with each other (i.e. overnight or day visits);
- Registered Nurse consultation;
- Locating housing; and
- Other staffing related costs necessary to successfully transition an individual into the community.

When new residential services are developed, planned, and implemented the usual administrative fee for the first month may be increased by an amount not to exceed $1,500 to reflect provider administrative costs required to develop new services. This increase shall be added as a line item to the ISL budget, or written in as a separate item on the shared living budget for the first month

of service. Future ISL and shared living budgets must reflect the provider's usual administrative fee within ISL and shared living guidelines. The combined cost for residential and reimbursement for increased administrative costs is not to exceed the cap for the daily rate of ISL or shared living arrangement for that initial month.

If an individual is moving to a group home where there is an existing vacancy, an existing ISL or shared living home, transition administrative costs may be negotiated up to an amount, not to exceed $500 for that person. If transition administrative costs are approved for group home service providers, they will be reimbursed under "res hab transition" code T2016 TG, for the first month of service only.

These administrative transition expenses will only be reimbursed to the provider after the person moves into the residential setting as an active waiver participant. Actual provider administrative expenses must be documented in detail and submitted to the RO during the first month of service. Documentation must include dates of service, specific administrative activity(ies), actual cost of each activity, names of staff members, total cost, etc. This cost accounting must be signed and dated by the provider.

HOME ACCESSIBILITY MODIFICATIONS

Waiver environmental accessibility adaptations/home modification services (up to $7,500), as well as specialized medical equipment and supplies (up to $7,500), may be accessed in advance of a person moving to the community. Only adaptations as per the service definition are covered when the specific need is documented within the transition plan.

Home accessibility modifications may be authorized in the waiver up to 180 consecutive days in advance of the individual's transition from Title XIX-funded facilities (e.g. ICF/AD, SNF). In such cases, the home modification begun while the person is living in the facility is not considered complete, and may not be billed until the date the individual leaves the facility and enters the waiver. The claim for reimbursement must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

FORMS

Initial Transition Meeting Guide

Risk Screening Guide

Transition Visit Profile

Inventory Checklist

Post-Transition Habilitation Center Review Form

Housemate Compatibility Survey (Detailed Version)

MONEY FOLLOWS THE PERSON

TRANSITIONS THROUGH MONEY FOLLOWS THE PERSON

MFP Eligibility

Individuals who transition from a Habilitation Center or nursing home may be eligible for MFP. MFP is a demonstration grant that supports efforts to:

- Provide Medicaid eligible individuals the choice of where they live and receive services;
- Allow qualified individuals living in nursing facilities or Habilitation Centers to move to the community; and
- Promote a system that is person-centered, based on needs, and ensures high-quality services in the community.

Participants must meet the following criteria:

- Be at least 18 years of age or older;
- Have lived in a state Habilitation Center or nursing facility for at least 90 days;
- Currently receive MO HealthNet benefits in the care facility prior to transition, even if only for one day; and
- Transition to a home that is leased or owned by the participant or participant's family, or move to residential housing with no more than four individuals living in the house.

MFP reimburses a portion of the funds that the State of Missouri uses to help individuals make a start in a new home.

People who qualify will participate in the demonstration grant for one year. After that year, services will continue as identified in their ISP.

Referral Process

As part of the planning process, an individual may be identified to move to the community from a nursing home or Habilitation Center. If so, the SC/Transition Coordinator and CLC will determine if the individual is eligible for MFP.

If the individual is eligible, the SC/Transition Coordinator will write the Individual's Transition Plan (ISP) and submit it to the URC to obtain pre-approval for services the person will need to make the move. The SC/Transition Coordinator will talk with the individual or legally responsible party and obtain a signed MFP participation agreement. The SC/Transition Coordinator will send the signed participation agreement to the CLC. The CLC will work with the SC/Transition Coordinator to gather all the information needed to make a referral to the MFP program through a web-based application.

The following statement must be maintained in an individual's ISP during the period they participate in the MFP program:

> As __Name__ is moving into a __number__ person ISL/group home, he/she is eligible for the Money Follows the Person demonstration. __Name's__ guardian has been notified of this option and has signed the agreement for their participation for one year. During this time, surveys will occur prior to discharge from _institution_, at one year and again at two years. If ___name___ is hospitalized or placed in an inpatient setting, regardless of the amount of time, the MFP project director (Julie Lamons: 573-751-8021) must be contacted. This will be the responsibility of __Support Coordinator name__, Support Coordinator. The ___area___ Regional Office provides a 24 hour call-in number for emergency back-up assistance if needed. ___Name___ and his/her guardian have been provided this number in the event that emergency back-up is needed.

Prior to the move, a Quality of Life Survey will be completed by a surveyor from the MFP program with the individual at the nursing home or Habilitation Center. This survey must be completed before the individual moves.

On the day the individual moves the SC/Transition Coordinator will inform the CLC that the individual has moved.

The Quality of Life Survey will be conducted again at the one year and two year post-move anniversaries. Quality of Life Surveys help demonstrate how MFP is making a difference in people's lives and adds an extra layer of assurance that participants are being heard.

Follow-up

Follow-up information regarding the outcomes from participating individuals is required to be submitted to the MFP program. Information is submitted through two methods. The CLC pulls reports, gathering information available in data systems such as data reported via event reports. Also, the SC completes and sends a monthly report to the CLC with additional information not previously reported through other methods.

FORMS

Money Follows the Person Participation Agreement

Money Follows the Person Support Coordinator Monthly Report

TRAINING LINK AND OTHER RESOURCES

Money Follows the Person Webinar

Money Follows the Person Tip Sheet

TRANSITIONS FOR INDIVIDUALS ON SEX OFFENDER STATUS

NOTIFICATION PROCEDURES FOR INDIVDUALS ON SEX OFFENDER STATUS

When an individual who is a registered sex offender will be residing in a residential setting with other individuals who receive DMH funded placement, Missouri Statute 630.127 outlines procedures required to notify individuals of the registered offender's status. Notification procedures also apply to an individual who has been found permanently incompetent to proceed to trial (NGRI) on an offense which would have required him or her to register as a sex offender had he or she been found guilty. If an individual who has been found NGRI goes into residential living with other individuals who receive DMH funded placement, the statute requires DMH to contact the individual's guardian to request permission to notify individuals with whom the individual will live of the charges for which the individual was found incompetent to proceed. The notification procedures also apply should an individual who currently receives residential placement becomes required to register or be found permanently incompetent to proceed on a charge covered by the statute.

Department Operating Regulation 4.270 provides specific procedures which DMH implements to comply with this statute. When a SC is seeking residential placement for an individual covered under this statute, the SC will contact the CLC at their RO for assistance to send proper notification letters. Notification letters must be sent prior to an individual, covered under the DOR, moving into a residential setting with other housemates.

When placement is sought for a juvenile who is required to register on the Missouri Highway Patrol Sex Offender Registry, the notification procedures outlined in DOR 4.270 will apply. If the juvenile is required to register on the Juvenile Sex Offender registry in their county of residence, consent to disclose information regarding the juvenile's legal status will be requested from the parent/legal guardian. Specific procedures for planning appropriate residential supports for juveniles who are registered offenders are also covered under the DOR.

Communication between the SC and CLC is key to ensuring all forensic notification procedures are followed. The SC should contact the CLC any time an individual, covered under DOR 4.270, seeks a residential setting. The CLC can also provide technical assistance to an individual's support team regarding housing and planning specialized supports for registered offenders and other individuals who display aberrant sexual behaviors.

ADDITIONAL TRANSITION TOOLS

Community Transition Service Tip Sheet

Safe and Sound: Tips to consider when looking for compatible housemates

AUTHORITIES

Missouri Home and Community Based Waiver

79 Fed. Reg. 2947

U.S. Supreme Court Olmstead v. L.C. Ruling

Individual Support Plan Guidelines

Missouri Statute 630.127

Department Operating Regulation 4.270